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Overview of attachment disorder and effective treatments for children

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Abstract

When children experience extreme chronic trauma as a result of the effects of the disruption of healthy attachment patterns, a disorder known as Reactive Attachment Disorder (RAD) can develop. The importance for mental health counselors to understand the etiology of RAD cannot be overemphasized. Symptoms most often associated with this disorder include the inability to trust, failure to develop intimate relationships, or show affection, lack of self-confidence, low self-esteem, and anti-social behaviors and attitudes (Levy & Orlans, 1998 as cited in Sheperis, Renfro-Michel, & Doggett, 2003). Highlighting the foundational work of Erikson, Harlow, Bowlby, and Ainsworth includes a brief overview of research studies in which several theorists have made important contributions to the work of attachment theory.

OVERVIEW OF ATTACHMENT DISORDER AND EFFECTIVE TREATMENTS
FOR CHILDREN

A Research Paper

Presented to

The Department of Educational Leadership, Counseling,
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In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts

by

Kathryn H. Hedican

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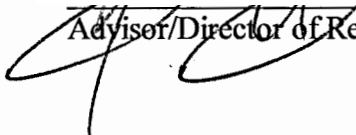
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Abstract

When children experience extreme chronic trauma as a result of the effects of the disruption of healthy attachment patterns, a disorder known as Reactive Attachment Disorder (RAD) can develop. The importance for mental health counselors to understand the etiology of RAD cannot be overemphasized. Symptoms most often associated with this disorder include the inability to trust, failure to develop intimate relationships, or show affection, lack of self-confidence, low self-esteem, and anti-social behaviors and attitudes (Levy & Orlans, 1998 as cited in Sheperis, Renfro-Michel, & Doggett, 2003). Highlighting the foundational work of Erikson, Harlow, Bowlby, and Ainsworth includes a brief overview of research studies in which several theorists have made important contributions to the work of attachment theory.

Overview of Attachment Disorder and Effective Treatments for Children

The parent-child bond is a relationship of profound importance. It has the potential of shaping who we are and who we eventually become. It is not difficult to imagine that what happens between a child and his or her caregiver will matter a great deal in the future. In Papalia, Olds, and Feldman (2004) attachment is defined as “a reciprocal, enduring emotional tie between an infant and a caregiver, each of whom contributes to the quality of the relationship” (p. 202).

When children experience extreme, chronic trauma as a result of the effects of the disruption of healthy attachment patterns a disorder known as Reactive Attachment Disorder (RAD) can develop. A necessary component in understanding RAD is to appreciate the importance of the development and nature of attachment in healthy relationships (Sheperis, Renfro-Michel, & Doggett, 2003).

Case Conceptualization

Joanie was the fourth child born to an impoverished family. In her third year of life the family home burned leaving the family homeless and without resources to care for the children. With the help of friends and relatives the children were placed in temporary homes. Joanie lived with a childless couple for several months. When Joanie's mother returned to take Joanie home the couple asked if it would be possible for her to live with them on a permanent basis. An arrangement was made and Joanie became an only child to this couple (her biological parents went on to have eight more children). Within a year's time Joanie's biological family moved to a state 2000 miles away. Before

leaving town they pulled up in front of the house to wave their goodbyes to Joanie, making the separation final.

The foster parents met Joanie's physical needs but did not display the skills necessary to meet her emotional needs. Even though Joanie did not experience abuse or neglect in her foster home the harsh realization of abandonment by her biological family played a part in future diagnoses of personality disorders and future relationships with lack of healthy attachments, not only in Joanie's life but in her children and grandchildren, as well. Her first-born child was sent from the home at the age of 16 to attend school in a state approximately 2000 miles away and her second child was a heavy drug user and a runaway at the age of 14.

Life brings unexpected loss and tragedy into the lives of children on a daily basis. Awareness, understanding, and professional skill in addressing the signs and symptoms of attachment disorder will give hope to children who would otherwise struggle to learn how to get their needs met.

This paper will explore several aspects of attachment disorder. The manuscript is divided into seven main sections covering criteria for diagnosis, characteristics of attachment disorder, theorists, secure and insecure attachment, treatment techniques, and finally, implications for the practitioner.

Criteria for Diagnosis

According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed. DSM-IV-TR), the American Psychiatric Association, the International Classification of Diseases (10th ed. ICD-10), and the World Health Organization (1992) attachment disorders are defined as resulting from pathogenic care or the persistent disregard for a

child's basic physical and/or emotional needs (Zeanah & Fox, 2004). In the DSM-IV-TR, two types present diagnostic features of attachment disorders. The *Inhibited Type* is represented by behavior that displays the inability to initiate or respond to social exchanges in an age-appropriate way. Patterns of behaviors in this type include that of being extremely inhibited, hypervigilant, or ambivalent with responses such as: resistance to nurturing or frozen watchfulness. The *Disinhibited Type* displays patterns of scattered attachments. The child shows indiscriminate selection in the choice of attachment figures and/or lack of sociability (American Psychological Association, 2000).

When considering a diagnosis of RAD differential diagnosis is a significant issue. Many RAD symptoms are characteristic of other pervasive disorders associated with developmental abnormalities, such as: conduct disorder, oppositional defiant disorder, and depression. According to a study by Muladdes, Bilge, Alyanak, and Kora (2000) there were 15 reported cases of RAD that were misdiagnosed as another pervasive developmental disorder. In order to accurately diagnose RAD it is important to be aware of exclusionary criteria. Without an accurate diagnosis suitable interventions are limited and complexities of RAD are compounded (Sheperis, et al. 2003).

Characteristics of Attachment Disorder

The importance for mental health counselors to understand the etiology of RAD cannot be overemphasized. Symptoms most often associated with this disorder include the inability to trust, failure to develop intimate relationships, or show affection, lack of self-confidence, low self-esteem, and anti-social behaviors and attitudes (Levy & Orlans, 1998 as cited in Sheperis et al. 2003). The domains within which the symptoms of RAD are expressed include: *physical self-perception, social, moral development, affect*

modulation, cognitive functioning, and behavioral. Symptoms exist on a continuum and may be experienced from severe to mild by a child within each of the domains (Sheperis, et al. 2003).

Physical Self-Perception

With regard to the domain of *physical self-perception*, children with attachment disorders may perceive themselves as victims even while they actively victimize others. Body distortion is a common experience. The distortion can include a feeling of depersonalization, poor impulse control, which presents as aggression toward others and self, and the lack of capability to enter into trusting social relationships. Sometimes poor physical hygiene is used as a method of keeping others at a distance, as well (Sheperis et al., 2003). Unattached children who do not learn how to identify with their own bodily experiences are at high risk for growing into adulthood as people who remain separated from not only their bodies but also their deepest feelings. At the extreme, psychopaths characteristically have extreme detachment from feelings and the ability to resist common pain (Magid & McKelvey, 1987).

Social Domain

In the *social* domain, relationships are often marked by unfair treatment and exploitation. Behaviors appearing charming and engaging are superficial and manipulative in nature (Levy & Orlans, 1998 as cited in Sheperis, et al., 2003). When an individual's ability to establish meaningful relationships is compromised as a result of a lack in early parent-child bonding the individual's psychosocial development is likely to exhibit characteristics of behavioral avoidance, low initiation of play, and low levels of open affection (Hanson & Spratt, 2000). A skilled therapist may find it difficult to

recognize children who are not attached, as some have varied characteristics to their personalities. Some wear a superficial mask, which often displays a likeable nature. Most often this charming side is verbally confident and is accomplished at making friends on a short-term basis fairly easily. The other side of the personality can present with traits such as cruelty to others, phoniness, abnormalities in eye contact, and lack of the ability to maintain long-term friendships (Magid & McKelvey, 1987). These children often utilize blame as a defense for mistakes and have trouble tolerating limits set by those in authority. Another symptom involving the *social* domain is the inability for trust and intimacy to be experienced. The attachment disorder makes emotional connections, even at a very basic level, feel threatening (Sheperis, et al., 2003).

Moral Development

Moral development can be thwarted and symptoms in this domain consist of the child developing a tit-for-tat philosophy. They usually lack compassion for others and/or remorse for errant behavior (Lynam, 1996, as cited in Sheperis, et al., 2003). Conscience is usually associated with moral dilemmas and includes both the ability to avoid doing something wrong and the emotional discomfort when something is done that is perceived as wrong (Papalia, Olds, & Feldman, 2004). It is not uncommon for a child with attachment disorder to enjoy watching the emotional or physical pain of others, nor do they usually care about premises of right and wrong (Sheperis, et al., 2003).

Affect Modulation and Self-regulation

According to Kopp (1982) two fundamental elements of early childhood development are affect modulation and self-regulation. *Affect modulation* is usually severely affected in children who experience neglect and maltreatment early in life. As a

result of physical and emotional needs not being met it is unlikely that children will learn to modulate states of arousal within themselves. They do not learn the skill of self-soothing and reject nurturing since they have learned to connect caregivers with a threat to their well-being. Children may inappropriately invade the personal space of others while at the same time rejecting the affection of others. Attitudes commonly displayed are those of being sulky, sullen, and pouty, as ordinary activities do not bring them pleasure (Sheperis, et al., 2003).

Cognitive and Behavioral Domains

The *cognitive and behavioral* domains blend together in many respects. Children with RAD are commonly deficient in cause-and-effect thinking. They are often self-defeating, suicidal, self-destructive, and self-mutilating (Lyons-Ruth, 1996, as cited in Sheperis, et al., 2003). As opposed to nonabused children, children who are abused will seek closeness to their caregivers in ineffective ways. Acknowledgement is given to the caregiver but no attempt for physical uniting is initiated. These children also form attachments that appear to be oppositional or compulsively compliant. They behave in ways that are avoidant and angry or overly intimate and clingy (Hanson & Spratt, 2000). Manipulation, fake sincerity, pathological lying, cruelty, and stealing are behaviors that signify a RAD diagnosis. Typically children will voice a strong desire for stable friendships but when intimacy or friendship is obtained they are frightened and usually sabotage the relationship (Sheperis, et al., 2003).

Theorists

This section provides a brief overview of important research in which several theorists have made important contributions to the work of attachment theory. Following is a highlight of the foundational work of Erikson, Harlow, Bowlby, and Ainsworth.

Erik Erikson

Erik Erikson (1902-1994) was born in Germany and was originally a psychoanalyst in Freud's circle. He expanded and adapted Freudian theory by putting emphasis on the influence of the culture on the growing personality. He is well known for developing a stage theory of psychosocial development and believed early experiences were key when determining appropriate versus inappropriate development. According to Papalia, et al. (2004) his theory has stood the test of time better than Freud's when it comes to the importance he placed on cultural and social development. He identified the time frame of birth continuing until the age of 12 to 18 months to be the age that most babies develop a sense of reliability about objects and people within their world. Healthy development will take place when the baby can develop a balance between trust and mistrust. When trust is established the infant will be able to form intimate relationships. When a healthy mistrust is learned it will help the baby protect him or herself (Papalia, et al., 2004). According to Erikson (1982, as cited in Papalia, et al. 2004) a virtue of hope develops when trust predominates. If children come to view the world as unpredictable and therefore cannot trust they will have difficulty forming healthy relationships. Erikson saw feeding time as a prime opportunity to establish the proper balance of trust and mistrust. When the baby can depend on being fed when hungry then an outer predictability as well as an inner certainty is achieved (Erikson, 1950, p. 247, as cited in

Papalia, Olds, & Feldman, 2004). He believed that initially the child's trust level of the caretaker enabled him/her to attain self-regulation in sleeping, feeding, and eliminating. Next, he said it allows the child to exist out of the sight of the caretaker without excessive anxiety. Finally, he believed it forms the basis for the child to have a healthy sense of identity and autonomy (Karen, 1994). In Erikson's third stage of development, "initiative versus guilt," conflict stemming from feelings about the self is at the heart of divergence that occurs from the search for a sense of purpose. This conflict defines a split between different aspects of the personality. The child that is able to regulate these opposing drives as a result of healthy attachments is able to develop courage to pursue goals without the fear or guilt of negative consequences (Erikson, 1982, as cited in Papalia, et al., 2004).

Henry Harlow

Harry Harlow and colleagues showed that feeding is not the only kind of stimulation babies get from their caregivers nor is it the most important. In a pioneering research, rhesus monkeys were raised in a laboratory after being separated from their mothers six to twelve hours after birth. The baby monkeys were placed in cages with either a wire-mesh surrogate mother covered with terry cloth or a wire-mesh surrogate mother in which a bottle for a food source had been attached. When the infant monkeys were allowed time with either "mother" all spent the majority of the time clinging to the terry cloth covered surrogate, even though no food could be obtained. In studies performed one year after the monkeys had had any contact with the surrogate mothers, the monkeys "raised" by the cloth covered wire form eagerly ran to be close and hug the form. Monkeys "raised" by the bare wire form showed no interest in any further contact

(Harlow & Zimmerman, 1959, as cited in Papalia, et al., 2004). These experiments show that the most important thing a baby monkey can receive from the mother is the comfort of close bodily touch and the contentment of an innate need to hug or cling (Papalia, et al., 2004).

Harry Harlow summarized the results of this study in a famous speech to the American Psychological Association: "These data make it obvious that contact comfort is a variable of overwhelming importance in the development of affectional responses, whereas lactation is a variable of negligible importance.... One function of the real mother, human or subhuman, and presumably of a mother surrogate, is to provide a haven of safety for the infant in times of fear and danger." (Blum, 2002, pp.159-160)

The final count of studies done by Harry Harlow, and the work he inspired, provides "a body of knowledge about the devastating effects of social isolation and their extreme resistance to treatment. Many people still do not appreciate how bad the effects are" (Blum, 2002, p. 288).

John Bowlby

Bowlby and Harlow were intensely alert to each other's work. and were natural allies in providing research to the field of psychology. Bowlby was in attendance at the American Psychological Association conference where Harlow summarized the results of his study (mentioned in previous section). Bowlby said, "I heard him speak and I saw his films, which had a very powerful effect on me." (Karen, 1994, p. 122) Each served as inspiration to the other in generating research on both children and monkeys to the extent that the fields of comparative psychology, psychoanalysis, child psychiatry, child

development, and ethology would from that time on become intertwined in new and innovative ways (Karen, 1994).

According to Bowlby (1969) attachment is an evolutionary process consisting of four stages and stems from the instincts of humans to survive as a species. The *first stage* consists of infants expressing needs of physical contact and closeness through natural cues such as crying and grasping. The infant's *second stage* of attachment begins between two and three months of age through about two years of age when the preference of caregiver is established through behaviors such as reaching and scooting. According to Bowlby, the *third stage* of attachment occurs simultaneously beginning around three months through the age of two as behavior is adjusted around the caregiver's actions and the infants and toddlers then act in accordance with these anticipated events. The consistent display of affection and attention to the child's needs is a component that is critical to the formation of healthy and stable adjustments of the child. Bowlby's *fourth stage* of attachment is characterized by an understanding of the development of reciprocity and caregiver independence in the relationship between the infant and caregiver. A consistent feature of all of the stages is the condition of behavioral reinforcement to the basic physical and emotional needs of the infant and toddler. The child is conditioned to utilize human relationships as a source of comfort and security (Wilson, 2001 as cited in Sheperis, et al., 2003).

Utilizing Mary Ainsworth's data, Bowlby advanced his strong beliefs regarding the ineffectiveness of an unfeeling style of caring for children. He argued that a stoic and emotionally cold approach to raising children did not build strong character and self-reliance in children. On the contrary, he believed that just the reverse was true—that self-

reliance depended on being securely attached to a caregiver that one fully trusted (Karen, 1994).

Mary Ainsworth

Mary Ainsworth, a Canadian psychologist, who had worked with Bowlby and had compatible views on attachment, began conducting research in the early 1960's. Her work was with babies at Johns Hopkins University and seemed to validate Bowlby's theory. In fact, Ainsworth was asked by Bowlby to take his place in a research project commissioned by the World Health Organization. She succeeded in producing a "brilliantly coherent statement" (Karen, 1994, p. 123) of the views that she and Bowlby shared. Ainsworth clarified the work into its constituent parts as she carefully examined scores of studies to assess and disentangle earlier confusing contradictions in the work. This was apparently no small task since it involved making sense of all the complexities, updating, and indicating where additional research would be helpful. In the end Ainsworth was able to very convincingly conclude that Bowlby's 1951 research was sound. Her performance won the respect of many people within the field and especially Bowlby who understood the role she played in furthering his original work (Karen, 1994).

Ainsworth and her colleagues, in a technique that was quite unusual for its time closely watched mothers and children in the home environment. Vigilantly the researchers took note of the mother's style of response to the infant in a variety of different areas: smiling, eye contact, cuddling, crying, and feeding. At the age of twelve months the mother and infant were observed in a lab in what Ainsworth labeled a "strange situation" (Karen, 1994). The Strange Situation, as it is now officially known, is

a sequence of eight experiences. Each episode or experience takes less than half an hour and consists of the mother twice leaving the baby in an unfamiliar room. The first time she leaves the baby with a stranger and the second time the baby is left alone. The second time the stranger comes back in the room before the mother does. When the mother enters the room with the stranger she encourages the baby to play and explore if needed (Ainsworth, Blehar, Waters, & Wall, 1978, as cited in Papalia, et al., 2004). Of utmost importance was the baby's response when the mother returned to the room (Papalia, et al., 2004). As a result of experimenting with the Strange Situation four main patterns of attachment were determined: secure attachment and three patterns of insecure or anxious attachment: avoidant, ambivalent, and disorganized (Papalia, et al., 2004; Jernberg & Booth, 2001).

Secure Attachment

The securely attached child is normally affectionate and can be calmed and comforted when in emotional or physical distress. The primary caregiver is someone who has characteristics of warmth, sensitive attunement to the child's needs, consistency and quickness to respond, and promotes shared and enjoyable interaction. At two years of age the securely attached child is persistent and enthusiastic when solving simple tasks. They are effective at utilizing assistance from the caregiver when a task becomes more difficult. By the time they enter school they show behaviors which are flexible, socially competent, curious, assertive, and self-reliant (Jernberg & Booth, 2001).

Insecure Attachment

Insecure attachment patterns are associated with parenting styles that are unresponsive, hurtful, or unavailable. As stated previously there are three patterns of

insecure attachment. Children around two years of age, who are ambivalently attached show little desire to problem solve, have a lack of self-reliance, and are whiney and easily frustrated. Around the age of two, avoidant children seem less able to connect to fantasy play and have a tendency to victimize other children. By the time they reach school age they appear to be oppositional and sullen and will decline help when disappointed or injured (Karen, 1990, as cited in Jernberg & Booth, 2001).

Disorganized children have parents who express fear themselves while at the same time reject the approach of the children. As can be imagined, when the child experiences an attack or fear that comes from what should be a safe place it provokes conflicting tendencies. The behavioral mannerisms in the particular children observed included pulling on their own ears and rocking. Even when apparently happy eye contact was avoided. It seems that children experiencing disorganized attachment have anger behavior that is highly correlated with the caregiver's resistance to contact initiated by the child (Jernberg & Booth, 2001).

Treatment Techniques

Currently there are a variety of treatments utilized within the field of counseling to treat the effects of attachment disorder. Because of the complexities of the disorder and the fact that the symptoms present in such a variety of ways there are many therapies worth reviewing that have proven effective in treatment. A brief overview of Theraplay, Attachment Therapy, and Holding Therapy are to follow, as these are therapies deemed to be effective in the treatment of attachment disorder.

Theraplay

Theraplay is an attachment-based play therapy that, according to the founders of the method, is an engaging, lively, and playful treatment method, which has the ability to produce positive and effective changes within the lives of children and their families in a relatively short amount of time (Jernberg & Booth, 2001).

The birth of Theraplay began when in 1967, the founder, Ann Jernberg accepted the position of director of psychological services for the Head Start program in Chicago. There was a mandate to find treatment for the children in Head Start but none was available to Jernberg at the time. Borrowing elements of work from Des Lauriers (1962, 1969, as cited in Jernberg & Booth, 2001) and Brody (1978, 1993, as cited in Jernberg & Booth, 2001) Jernberg went about developing a new approach. Tapes were made to demonstrate the effectiveness of the work being done and the method gradually gained acceptance and recognition. The name Theraplay was officially coined in 1970 and one year later the first Theraplay classes were taught, as well as the establishment of the Theraplay Institute (Jernberg & Booth, 2001).

Since that time it has evolved in relationship to the growing knowledge about the nature of attachment disorder and has expanded its focus accordingly. This therapy addresses four serious problems that thwart the healthy development of a secure attachment relationship. These include: insufficient *nurturing* touch; inadequate *structure* in daily life; too little personal *engagement*; and failure to give the correct kinds of *challenge* (Jernberg & Booth, 2001).

Theraplay is distinguished from other treatment methods by the following innovative interventions (Jernberg & Booth, 2001):

- “The Theraplay therapist takes charge, carefully planning and structuring the sessions to meet the child’s needs rather than waiting for the child to lead the way.
- The therapist does all in her power to entice the child into a relationship, including, if necessary, intruding on the child in order to begin the engagement. Treatment emphasizes the interactional relationship between the therapist and the child rather than focusing on conflicts with the child’s psyche.
- Nurturing touch is an integral part of the interaction.
- The therapist remains firm in the face of resistance, whether passive or active. If the child responds with anger, the therapist stays with the child throughout the duration of the angry outburst.
- Treatment involves active, physical, interactive play. There is no symbolic play with toys and very little talk about problems.
- Treatment is geared to the child’s emotional level and therefore often includes “babyish” activities that many people would consider appropriate for a younger child.
- Parents are actively involved in the treatment to enable them to take home the new ways of interacting with their child.
- The therapist initially steps into the parental role in order to model for the watching parents, a new way of relating to their child.” (p. xxviii)

In the specific treatment of attachment disorder the goal of Theraplay is to recreate the pattern of healthy interactions that lead to secure attachment taking place

between caregivers and their very young children. It is believed that regardless of the age of the child a benefit will occur from the experience of practicing the healthy behaviors with caregivers. Bonds of affection and trust grow between the caregiver and the attachment disordered children, which allows the children to feel safe enough to be able to relax their need to be in charge of the interactions with the caregiver (Jernberg & Booth, 2001).

Currently Theraplay is a method of treatment for children with a variety of disorders. These include: Autism and Pervasive Developmental Disorder (PDD), Attachment Disorder, Attention Deficit Hyperactivity Disorder (ADHD), angry and aggressive children, and depressed children (Theraplay Treatment for Children, 2001).

Since physical touch is one of the beliefs of Theraplay, there must be every precaution taken to assure that there can be no accusations of inappropriate contact. One of the techniques that set Theraplay apart from other forms of this type of therapy is the inclusion of the caretaker as an observer or a participant in the session. It would behoove any therapist practicing this method of treatment to utilize legally appropriate release/consent forms.

Attachment Therapy

Attachment Therapy, developed by Michael Orlans and Terry Levy (2004), is a treatment that involves systemic, holistic interventions, the creation of secure attachment patterns, and using a structure that will developmentally allow the child to revisit, revise, and revitalize.

The primary goal of Attachment Therapy is to make possible a secure attachment presently in the child-parent relationship. This is achieved by recreating the components

of a secure attachment that were unavailable when the child was in the early developmental stages. Holding Nurturing Process (HNP) is utilized to provide children with empathy, support, positive affect, structure, and love. HNP provides a therapeutic environment, which promotes the development of a secure base, safe containment, social releasers, and corrective touch (Orlans & Levy, 2004).

Systemic Approach

There is a systemic approach to Attachment Therapy that looks at the attachment issue in the context of interconnecting relationship systems. These include: community, extended relatives, immediate family, marriage relationships, and naturally the parent-child interaction.

In this short term therapeutic approach treatment is viewed as developmental and requires the achievement of each stage as necessary before advancing to the next stage. Core issues of the actual trauma are addressed initially as a way of revisiting the concerns that are the basis of the disorder. Next, belief systems, relationship patterns, coping skills, and choices are revised to learn more effective means to build connections. Lastly, achievements are celebrated, positive changes are validated and encouraged, and hope for the future is promoted as a way to envision revitalization (Orlans & Levy, 2004).

Holding Therapy

The therapeutic intervention called Holding Therapy is a controversial treatment with critics and proponents. Strong criticism found in the literature described Holding Therapy as a “controversial (and sometimes fatal) approach to treatment of children with RAD” (Werner-Wilson & Davenport, 2003, p. 182). Werner-Wilson and Davenport (2003) say that the treatment components include: extended restraint for reasons other

than protection; prolonged stimulation that involved poking and tickling; and interference of physical functions. "Parents may be told that this is the only way to keep their child from becoming a serial killer, murderer, or psychopath" (Hanson & Spratt, 2000, p. 142, as cited in Werner-Wilson & Davenport, 2003).

Martha Welch, inventor of a holding therapy called holding time, began using this therapy at the Albert Einstein College of Medicine for children who suffered with autism. According to her, holding time is a practical method for a caregiver to utilize in order to achieve a satisfying, close, and wonderful relationship with a child.

The technique involves holding a child in a position that allows direct eye contact between the child and caregiver while controlling the child's attempts to struggle, protest, or escape. A specific sequence is normally seen in responses of holding that involve confrontation, rejection, and resolution, in that order.

First the caregiver sits comfortably with the child on the lap, face-to-face. Whether the child protests or is happy the caregiver verbally expresses his/her feelings to the child. If the child tries to withdraw strength and tenacity are used to intensify the contact. If the caregiver is able to persevere throughout the period of rejection by the child, the interchange dissolves into a tender and intimate exchange. As sessions of this kind are repeated the experience serves as a foundation for a secure attachment to grow. The effect on the caregiver also can prove to be profound, as self-esteem grows and the capacity to cope with the child increases. The improvement in the well being of both caregiver and child in turn affects the other family/support system (Welch, 1988).

According to Hage (2001) holding therapy is normally utilized when other choices have been exhausted and there are few options left to consider. It is what many

parents turn to before considering institutionalization. Two significant goals of holding therapy include: (1) allowing the child to release memories and emotions in a safe place. Usually these are emotions that served as a defense for the child but are now blocking the child from opening up to trusting and safe relationships. Sometimes the child screams and/or sobs during the holding session. The most considerable aspect of holding is what happens after the grief and rage is spent. This is when the child is finally in a relaxed state and is able to accept the concern and love of others. The child is finally able to trust that he will not be abandoned or hurt. (2) A corrective emotional experience is the second goal of holding therapy. Holding therapists would contend that children who have been abused by painful touching need to be held close, even through an emotional episode, and then realize resolution without being harmed. The experience of holding by someone safe and gentle retrains the child to view touch as something that is healing and helpful as opposed to harmful (Hage, 2001).

Implications to Practitioners

A wealth of research has been completed on attachment theory. Our knowledge and understanding of this subject has been greatly enhanced as we seek to learn the development of psychopathology and the role of child-parent relations. In order to apply attachment theory to practice one must provide an attachment-oriented framework that serves to guide the therapist in the functioning of a practice effective in treating disorders based upon attachment issues.

Considering the description of RAD in the DSM-IV-TR some would suggest that family therapy would be one of the first choices of treatment since it is connected to a child receiving "pathogenic" care. Therefore it would seem that involving the family in a

systemic approach would be in the best interest of the child. However, the majority of recent scientific writing emphasizes utilizing an individualistic approach in which the child is the main aim of intervention. Treatment of RAD most often is based on the supposition that the client has bottled up anger that stands in the way of creating an attachment. Clinical involvement is devised to help release the rage and help the child learn that the caregiver is ultimately in control (Werner-Wilson & Davenport, 2003).

Another implication to consider in the treatment of RAD is the potential dynamic in the relationship between the child with complex needs and serious attachment difficulties and the professional who is endeavoring to help him/her. A difficulty that is likely to occur is an unplanned attachment relationship between the child and the counselor. A relationship such as this is very important to anticipate and take measures not to allow. To successfully accomplish keeping professional boundaries in place takes maturity, forethought, prescience, and the understanding of the importance to all parties involved of long-term consequences. It is the therapist's role to help the caregivers of the child recognize and respond appropriately to the distorted, difficult, and unhealthy attachment patterns so as to learn how to finally meet the needs of the child and form the attachment with someone who is available on a long-term basis (Ryan, 2004).

As a practitioner working with clients with attachment disorder it is necessary to be very well versed in the patterns of childhood behaviors, developmental milestones, and other comprehensive classification systems that would allow adequately diagnosing the client. It would serve the therapist well to be highly trained in a specific psychotherapeutic treatment and also keep in mind that the central factor for a successful outcome is usually the relationship between the client and the practitioner. Other

techniques and procedures to consider are establishing protocol for the initial contact with the client, method of scheduling and frequency of visits, appropriate consents and releases, and issues of termination (Brisch, 2003).

The importance for mental health counselors to understand the etiology of RAD cannot be overemphasized. Awareness, understanding, and professional skill in addressing the signs and symptoms of attachment disorder will give hope to the caregivers and the children like Joanie who would otherwise struggle in learning how to get their needs met.

Conclusion

Evidenced in the historical research definite fundamental themes of relatedness and personality styles originate in infancy, as well as the basic tenets of human emotional life. Attachment researchers are interested in answers to questions such as: How are expectations of others formed? What affects self-perception in the context of an intimate connection? Why are unsuccessful strategies utilized in efforts to get needs met that were denied in childhood? Research has attempted to show how insecurities present in a variety of childhood behaviors—including emotional withdrawal, extreme aggressiveness, and inability to focus or attend to the task at hand (Karen, 1994).

Well-established research shows that insecure attachment disorder is evident at twelve months of age and is a predictor of behavior from the age of three throughout the lifespan. Researchers have attempted to determine that insecure patterns of attachment are not a permanent condition but can be changed as adjustments are made in care giving or later in adulthood when attempts can be made to work through earlier experiences (Karen, 1994).

John Bowlby, discussed earlier and sometimes referred to as the founder of attachment theory, believed that the first relationship of one's life determines the future well being of that individual. It was his belief that the needs of the infant include affectionate relationships. He wrote (Karen, 1994):

“When a baby is born he cannot tell one person from another and indeed can hardly tell person from thing. Yet, by his first birthday he is likely to have become a connoisseur of people. Not only does he come quickly to distinguish familiars from strangers but amongst his familiars he chooses one or more favorites. They are greeted

with delight; they are followed when they depart; and they are sought when absent. Their loss causes anxiety and distress; their recovery, relief and a sense of security. On this foundation, it seems, the rest of his emotional life is built—without this foundation there is risk for his future happiness and health” (p. 5)

In sum, attachment disordered children’s mental health care is dependent on mental health care professionals taking appropriate measures to (a) ensure that the child is placed in a secure and nurturing environment, (b) make the identification of RAD as early in treatment as possible, (c) focus on coping skills as opposed to vague pathologies, (d) work closely with the child’s caregiver in order to teach them effective parenting skills, (e) maintain the child in the least intrusive and least restrictive level of care (Hansen & Spratt, 2000).

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